

DO NOT TEAR OUT
 WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Jackson
 Civil Dist. 9
 OR
 Village _____
 OR
 City _____ (No. _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH

File No. 3

2 FULL NAME Plitha Haney

Registered No. _____
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX FM 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow
 (Write the word)

6 DATE OF BIRTH Oct 10 1868
 (Month) (Day) (Year)

7 AGE 58 yrs. 4 mos. 4 ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION Housekeeping
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Tenn

10 NAME OF FATHER Lige Haney

11 BIRTHPLACE OF FATHER [State or country] Tenn

12 MAIDEN NAME OF MOTHER Sallie Loftis

13 BIRTHPLACE OF MOTHER [State or country] Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] Rosey Loftis
 [Address] Cookeville

15 Filed Mar 14 1927 A. M. Ballard
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 14 1927
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from _____ 192, to _____ 192, that I last saw him alive on _____ 192,

and that death occurred, on the date stated above, at _____ M
 The CAUSE OF DEATH* was as follows: 2056

unknown no medical aid
 [Duration] yrs. mos. ds.

Contributory [SECONDARY] _____
 [Duration] yrs. mos. ds.

Signed _____ M. D.
 _____ 192 Address _____

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS TRANSIENTS, OR RECENT RESIDENTS]
 At place of death _____ yrs. mos. ds. In the State _____ yrs. mos. ds.
 Where was disease contracted, if not at place of death?
 Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Honey Cemetery DATE OF BURIAL Feb 15 1927

20 UNDERTAKER none ADDRESS _____